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Issue Date: 15 July 2005

Case No. 2004-BLA-6492

In the Matter of:

ALFRED WILLIAM HILL
Claimant

v.

KOCH CARBON RAVEN DIV.,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Joseph Wolfe, Esquire
For the Claimant

H. Ashby Dickerson, Esquire
For the Employer

Before: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER—DENYING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 412, 718, and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was

caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

At a formal hearing conducted in Abingdon, Virginia on December 6, 2004, all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations. At the hearing, the Director's exhibits 1-80, Claimant's exhibit 1, and Employer's exhibit 1 were admitted into evidence without objection. Tr. 9, 12, 13. In addition, I granted Claimant permission to depose Dr. Forehand and offer his deposition as rebuttal to EX 1, and I granted Employer permission to submit rehabilitation evidence from Dr. Rosenberg, if necessary, following Dr. Forehand's deposition. Tr. 15-16.

Dr. Forehand's deposition transcript was received by my office on February 7, 2005, marked as CX 2, and is hereby admitted into the record. Dr. Rosenberg's corrected rehabilitative report was received by my office on April 13, 2005, marked as EX 2, and was also admitted into the record. In addition, by Order dated April 19, 2005, the parties were instructed to file post-hearing briefs on or before June 7, 2005. Employer's brief, dated June 7, 2005, was received by my office on June 10, 2005. Claimant's brief was dated June 13, 2005 and received June 17, 2005. Claimant asked that the brief be accepted out of time due to illness. Employer did not object to Claimant's brief being filed out of time. Accordingly, good cause being shown, I accept Claimant's brief out of time and the record is now closed.

ISSUES

The contested issues are:

1. Whether Claimant has pneumoconiosis;
2. Whether the pneumoconiosis arose out of Claimant's coal mine employment;
3. Whether the miner is totally disabled due to pneumoconiosis; and
4. Whether the miner has established a change in condition pursuant to 20 C.F.R. §§ 725.309 and 725.310 (2003) (duplicate claim and modification);
5. Whether there was a mistake in a determination of fact pursuant to 20 C.F.R. § 725.310

(Tr. 5-7; DX 77)

[1] The following abbreviations have been used in this decision: DX = Director's exhibit; EX = Employer's exhibit; CX = Claimant's exhibit; Tr. = Transcript of the hearing; BCR = Board-certified radiologist; and B = B reader of x-rays.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[2]

Procedural History

Claimant, Alfred William Hill, filed this second claim for benefits on March 19, 2001.[3] (DX 3) The District Director awarded benefits by Proposed Decision and Order on April 30, 2002. (DX 31) The employer disagreed with the determination and requested a formal hearing. By Decision and Order dated July 30, 2003, Administrative Law Judge Linda S. Chapman denied benefits. (DX 57) Claimant appealed the Decision to the Benefits Review Board ("the Board") and also requested modification with the District Director. (DX 59, 60) Accordingly, the Board dismissed Claimant's appeal and remanded the case to the District Director for modification proceedings. (DX 60)

In a Proposed Decision and Order dated March 9, 2004, the District Director Granted Claimant's request for modification. (DX 69) Employer challenged the findings and requested a formal hearing before the Office of Administrative Law Judges on April 5, 2004, and the case was forwarded to the Office of Administrative Law Judges on July 1, 2004 for hearing. (DX 71, 77) A hearing was held on December 6, 2004 in Abingdon, Virginia.

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Background

At the hearing, Claimant testified as follows:

He worked approximately 25 years in coal mining, with all of the work underground and most of those years at the face of the mine. Tr. 18. Claimant testified that he stopped working in 1994 when the mines closed down but began having breathing problems in 1991 or 1992. Tr. 18, 19. He explained that he could not go back and do any of his previous work because during the last eight or ten years of his job, he had a lot of help in order to keep his position. Tr. 19-20. Claimant testified that Dr. Forehand has been his treating physician for fourteen years, and that he has two dependents, his wife, Joyce, and son, Ethan, who is fourteen years old. Tr. 19. Claimant explained that this son is actually his adopted grandson and that he adopted him after he filed his application in March 2001. Tr. 20-22.

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[2] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718 (i.e., March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in Virginia, this claim arises under the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

[3] Claimant's first claim for benefits, dated May 10, 1994, is administratively closed and not subject to adjudication. (DX 34)

Claimant testified that he completed the sixth grade and started smoking at age nineteen, although he experimented with cigarettes before then but couldn't afford them. Tr. 23. He explained that he smoked about a pack of cigarettes per day and stopped smoking in November 1987. Tr. 23-24. Claimant testified that he still uses chewing tobacco. Tr. 24.

Modification and Duplicate Claim

Claimant submits that the evidence establishes a material change in condition pursuant to 20 C.F.R. § 725.309(d) (2003). This section provides that if a claimant files a claim *more than one year* after a previous claim is finally denied, the later claim shall be considered a subsequent claim for benefits (emphasis added). As such, the new evidence submitted in connection with the subsequent claim must establish a change in at least one condition of entitlement previously adjudicated against the claimant, or the claim shall be denied. *Id.*

The regulations further provide that modification of an order may be sought at any time before one year after the denial of the claim. Specifically, the terms of an award or the decision to deny benefits may be reconsidered upon the showing of a "change in conditions" or a "mistake in a determination of fact." 20 C.F.R. § 725.310 (2003). In evaluating a request for modification, it is not enough that the administrative law judge conduct a substantial evidence review of the district director's finding. Rather, the parties are entitled to *de novo* consideration of the issue. *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *aff'd on recon.* 16 B.L.R. 1-71 (1992); *Dingess v. Director*, *OWCP*, 12 B.L.R. 1-141 (1989); *Cooper v. Director, OWCP*, 11 B.L.R. 1-95 (1988). In addition, even if a change in conditions is not established, evidence must be considered to determine whether a mistake in a determination of fact was made, even where no specific mistake of fact was alleged. *See O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971); *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993); *Consolidation Coal Co. v. Director, OWCP [Worrell]*, 27 F. 3d 227 (6th Cir. 1994).

Claimant's first claim was finally denied by the Benefits Review Board, which affirmed Administrative Law Judge Thomas Burke's Decision and Order Denying Benefits on September 28, 1998. (DX 1) Judge Burke found that the claimant did not establish that he suffers from pneumoconiosis or that he is totally disabled due to pneumoconiosis. In this, his current claim for benefits, Administrative Law Judge Linda Chapman found that although Claimant established the presence of pneumoconiosis, thereby establishing a change in condition, he did not establish that he is totally disabled due to pneumoconiosis on the merits. Claimant subsequently requested modification of Judge Chapman's decision. Consequently, this case is essentially a request for modification of a duplicate claim. Accordingly, I will first determine whether Claimant has established a change in condition of entitlement pursuant to 20 C.F.R. §§725.309(d) and 725.310 (2003) and I will also evaluate whether Judge Chapman made a mistake in a determination of fact pursuant to § 725.310. *O'Keefe*, and *Jessee*, *supra*.

Claimant's previous claim was denied because the evidence did not establish that he suffers from pneumoconiosis or that he is totally disabled due to pneumoconiosis. Thus, in order for Claimant to prove a change in conditions, the new evidence must be evaluated to determine whether any of those elements can now be established. After considering the most recent evidence in the record, I find that Claimant has established that he suffers from pneumoconiosis,

which is an element of entitlement previously adjudicated against him. In addition, after evaluating the medical evidence, I find that Judge Chapman accurately summarized the evidence of record that was before her at the time and that she did not make a mistake of fact in finding that Claimant suffers from pneumoconiosis but did not establish that he is totally disabled from a pulmonary standpoint.

Medical Evidence

Chest x-rays

The record contains the following chest x-ray evidence:

Exhibit No.	Date x-ray	Physician/Qualifications	Interpretation
DX 18	7/19/01	Patel/BCR, B	2/1; r/r.
DX 30	1/18/02	Poulos	2/1; r/r.
DX 53	9/16/02	Castle/B	2/1; r/q.
DX 53	9/16/02	Wheeler/BCR, B	0/1.
CX 1	10/7/04	Forehand/B	2/3; r/r. Extensive Reticulonodular fibrotic changes bilaterally, apically and centrally without definite acute infiltrates. Heart size and pulmonary vascularity are unremarkable. Stable exam of the chest along with the extensive fibrosis involving the upper and mid-lung fields without radiographic findings of acute cardiopulmonary disease or significant change from 8/12/03.
EX 1	11/4/04	Halbert/BCR, B	2/3; r/r.

Pulmonary Function Studies[4]

The record contains the following pulmonary function study evidence:

Ex. No.	Date	Age	Height	FEV1	MVV	FVC	FEV1/FVC%	Qualify?
DX 1	3-22-88	39	65”	2.69	117	3.79		No.
				*2.90	*134	*3.98		No.
DX 1	3-10-89	40	67”	2.42		3.65		No.
				*2.86		*4.00		No.
DX 1	9-18-93	45	65”	2.33	103	3.45		No.
				*2.71	*125	*3.85		No.
DX 1	6-6-94	45	65”	2.24	87	3.41		No.
				*2.59	*116	*3.82		No.
DX 1	7-11-95	47	66”	2.20	59	2.98		No.
DX 1	8-22-96	48	66”	2.26	74	3.53		No.
				*2.30		*3.48		No.
DX 30	8-2-99	50	65”	2.13		3.14		No.
				*2.22		*2.96		No.
DX 30	2-18-00	51	65”	2.12	55	3.39		No.
				*2.14		*3.37		No.
DX 18	7-19-01	52	65”	2.04	56	3.20	64%	No.
				*2.12	*76	*3.30	64%	No.
DX 30	1-18-02	53	66”	2.08	67	3.35	62%	No.
				*2.32	*90	*3.41	68%	No.
DX 53	9-16-02	54	66”	1.93	48	3.14	62%	No.
				*2.06		*3.29	62%	No.
CX 1	10-7-04	56	66”	2.01	43	3.30	61%	No.
				*2.21	*47	*3.59	*62%	No.

Comments: Expiratory volumes and flows are reduced. There is no evidence of hyperinflation or air trapping. Airflow conductance is below the normal range. Bronchodilator results in no significant improvement in ventilatory status. Oxygen saturation falls with exercise. Inspiratory

[4] The miner’s height was reported both as 65, 66, and 67 inches. For purposes of determining qualifying disability values, I find that the miner’s height equals 65.6 inches.

and expiratory flow volume curves are not indicative of upper airway obstruction. Irreversible obstructive ventilatory pattern. Exercise induced arterial hypoxemia.

EX 1	11-4-04	56	66”	1.83	32	3.02	61%	No.
				*2.04	*37	*3.25	*63%	No.

Comments: Mild obstruction, no restriction. Definite bronchodilator response. The diffusing capacity corrected for lung volumes is normal, indicating there is no loss of the alveolar capillary bed. Air trapping is not present. Patient understood test and cooperated well with good effort.

* = Post-Bronchodilator

Arterial Blood Gas Studies

The record contains the following arterial blood gas study evidence:

Ex. No.	Date	pO2	PCO2	Qualify?
DX 1	3-10-89	86	42	No.
DX 1	9-18-93	77	40	No.
DX 1	2-5-94	88	34	No.
DX 1	6-6-94	74	38	No.
DX 1	8-22-96	83	37	No.
DX 30	2-18-00	73	38	No.
DX 18	7-19-01	71	36	No.
		*59	*35	Yes.
DX 53	8-15-02	81	37	No.
		*107.8	*33.4	No.
DX 53	9-16-02	76.7	42.7	No.
CX 1	10-7-04	75	39.0	No.
		*65	*41.0	No.
EX 1	11-4-04	86.3	37.3	No.

* = Post-Exercise

Medical Reports

Hospitalization Records and Treatment Notes

The record contains the progress reports and treatment notes of Dr. J. Randolph Forehand. These reports appear in the record at DX 59. A letter from Dr. Forehand to the miner dated August 28, 1998 indicates that a chest x-ray was 2/2, q/q and a CT scan of the chest taken August 21, 1998 showed diffuse reticulonodular lung disease indicative of coal workers' pneumoconiosis. A tuberculosis test was negative. Dr. Forehand instructed the miner not to return to the coal mines to avoid further injury to his lungs.

A second letter from Dr. Forehand to the miner is dated August 16, 2000. In the letter, Dr. Forehand explains that spirometry taken on August 8, 2000 illustrates the degree of respiratory impairment, leading to the miner's disabling shortness of breath. He explained that a CT scan of the chest, taken August 10, 2000, reveals diffuse interstitial fibrosis that is seen in 20% of disabled coal miners with coal workers' pneumoconiosis. Dr. Forehand informed the miner that he does not have the respiratory capacity to return to coal mining and further exposure to coal dust will only aggravate his lung disease, worsening his shortness of breath. He provided the results of the miner's chest x-ray, pulmonary function tests, and arterial blood gas study and noted that the miner's exercise blood gas study was abnormal. Dr. Forehand stated that with only a mildly abnormal spirogram and normal DLCO, cigarette smoking does not appear to play a substantial role in the miner's respiratory impairment. He informed the miner that without the underground coal mine employment history, he would not be experiencing shortness of breath to such a degree.

The record contains a progress report from Dr. Forehand dated August 12, 2003 of an examination performed on the same date. This report appears in the record at DX 63. Dr. Forehand's impression was: 1) Severe coal workers' pneumoconiosis with respiratory impairment of a gas exchange nature. No evidence of significant impairment stemming from cigarette smoking. No evidence of systolic dysfunction; 2) Unexplained nine pound weight loss.

A third letter to the miner is dated August 13, 2003. It appears in the record at DX 67. In it, Dr. Forehand explains that the miner's recent pulmonary evaluation indicates worsening coal workers' pneumoconiosis and no evidence of significant smoker's lung disease or cardiac dysfunction

Physician Opinion Reports

Dr. Larry Mitchell

Dr. Mitchell examined the miner on March 22, 1988 for a history and physical exam. Dr. Mitchell noted that the miner works as a coal miner and smokes one pack per day. He recorded that the miner complained of chest pain and dyspnea for about two months. The miner's pulmonary function test revealed an obstructive component to airflow through the mild

airways with improvement after administration of bronchodilators. Dr. Mitchell's impression was: 1) Dyspnea on exertion, probably secondary to early COPD; 2) chest pain of uncertain etiology, rule out coronary artery disease; 3) history of recurrent heartburn, rule out peptic ulcer; 4) mild hypercholersterolemia; 5) history of cigarette use; 6) history of leg cramps of uncertain etiology.

Dr. J. Dale Sargent

Dr. Sargent, who is board-certified in internal medicine, pulmonary diseases, and is a B-reader, examined the miner on August 22, 1986 in connection with his previous claim. His report appears in the record at DX 1. Dr. Sargent performed objective tests that included an EKG, ventilatory study, arterial blood gas study and chest x-ray. Dr. Sargent noted that the miner could walk about a mile without stopping but gets short of breath if he walks quickly or up hill. He recorded a 25 year underground coal mine employment history and assumed that the miner performed heavy manual labor. Dr. Sargent opined that the miner suffers from a mild ventilatory impairment that is non-disabling and he clearly retains the respiratory capacity to perform his last coal mine job as a foreman and as Claimant described the job duties to him.

Dr. Ranavaya

The Department of Labor requested that Dr. Ranavaya review the miner's medical records in connection with his previous claim. He submitted a report dated May 14, 1996, which appears in the record at DX 1. Dr. Ranavaya opined that based on his review of the record, the miner does not have evidence of CWP because Dr. Forehand's examination report from June 6, 1994 did not report any evidence of CWP. Dr. Ranavaya opined that the miner is not totally disabled.

Dr. Gregory J. Fino

Dr. Fino reviewed the miner's medical records in connection with his previous claim. His report appears in the record at DX 1 and is dated May 16, 1997. Dr. Fino opined that the miner is not disabled from a pulmonary standpoint and could return to his last mining job. Dr. Fino noted that the miner worked for 25 years in the mines as a foreman and his job required him to sit and stand for an hour a day, crawl a distance of 1800 feet for six hours per day, and to carry 50 pounds for fifteen feet per day. Dr. Fino opined that the miner has a mild, reversible respiratory impairment due to smoking and regardless of the cause of the impairment, he is neither partially nor totally disabled from returning to his last coal mining job or similar job.

Dr. John Randolph Forehand

Dr. Forehand examined the miner in connection with his prior claim on June 6, 1994 and submitted Form CM-988. He recorded that the miner had 25 years of underground coal mining employment, and attached the miner's occupational history Form CM 911a for reference. Dr. Forehand recorded the miner's family medical history as positive for high blood pressure and stroke in his mother, high blood pressure in his sister, and diabetes in his brother. Dr. Forehand

noted that the miner suffers from pleurisy and attacks of wheezing, and suffered a back injury in a mine accident. He also noted that the miner underwent surgery on his right knee.

Dr. Forehand recorded that the miner currently smokes one pack of cigarettes per day, and began smoking in 1969. He recorded the miner's chief physical complaints as wheezing at night, dyspnea with any activity, and two pillow orthopnea. The miner's physical exam was essentially normal. Dr. Forehand performed objective tests that included a chest x-ray, ventilatory studies, arterial blood gas studies, and an EKG. Dr. Forehand noted that the ventilatory studies revealed a partially reversible obstructive ventilatory pattern, and the arterial blood gas study revealed no hypoxemia at rest or with exercise and no metabolic disturbance.

Dr. Forehand's cardiopulmonary diagnosis was chronic bronchitis from cigarette smoking and coal dust exposure. He stated that the miner demonstrates a mild to moderate impairment and exertional activities, and dusty conditions may very well aggravate his ventilatory status so a change in location is recommended.

Dr. Forehand examined the miner on October 7, 2004, in connection with his petition for modification of his current claim. His treatment notes appear in the record at CX 1. Dr. Forehand is board certified in pediatrics, allergy & immunology, is board-eligible in pediatric pulmonary medicine, and is also a B-reader. (CX 2)

Dr. Forehand noted that the miner was seen in his respiratory clinic for follow-up for complaints of exertional shortness of breath. He noted that the miner reported needing to stop and rest following any physical activity, including bathing, dressing, or walking from room to room in his house. Dr. Forehand noted that the miner has an occasional cough productive of minimal amounts of light gray, nonbloody sputum, and his breathing is worse at night unless he sleeps with two or three pillows. Dr. Forehand noted that the miner's medical history is positive for hypertension, diabetes, and that he uses a nebulizer three or four times per day. He noted that the miner's cardiac stress test in October 2002 was normal, that the miner worked in underground coal mining for 23 years and smoked cigarettes for 30 years, stopping in 1997.

Physical examination revealed no clubbing or cyanosis, normal thorax, and no intercostal retractions. The breath sounds were diffusely diminished, inspiratory crackles were heard at the bases, no wheezes were heard, expiration was not prolonged, precordium was quiet, PMI not displaced, no murmurs were heard, and the abdomen was obese but otherwise soft, nontender, and no unusual pulsations were noted. Dr. Forehand performed objective tests including a chest x-ray, spirometry, and an arterial blood gas study. Dr. Forehand's impression was: 1) coal workers' pneumoconiosis; 2) exercise induced arterial hypoxemia.

Dr. Forehand also testified in a deposition on January 10, 2005. The deposition transcript appears in the record at CX 2.[5] Dr. Forehand testified that he has practiced medicine for 26 years, conducted black lung examinations for fourteen years, and has performed approximately 4,000 black lung examinations at the request of the U.S. Department of Labor, individual coal

[5] At the hearing, I granted Claimant permission to conduct the deposition solely as rebuttal to Dr. Rosenberg's report, which appears in the record at EX 1. Tr. 15.

miners, and coal mine employers. CX 2 at p. 3. He testified that he has treated the miner for approximately ten years, and sees him approximately twice a year. CX 2 at p. 10.

Dr. Forehand testified that the pulmonary function study in Dr. Rosenberg's report shows impairment but exceeds the Department of Labor disability values. CX 2 at p. 14. He explained that the FEF 25/75 is a flow measurement, not used by the Department of Labor, and the miner's values in Dr. Rosenberg's study are indicative of impairment. *Id.* Dr. Forehand testified that Dr. Rosenberg's arterial blood gas studies were not conducted using the Department of Labor standards because exercise values weren't taken. CX 2 at p. 15. He explained that the regulations require that if the resting results exceed the cut off values, as in the miner's case, then an exercise blood gas test should be conducted. *Id.* He further explained that pulmonologists know that a person who gets short of breath on exertion may have very normal resting blood gas values and that exercise is the best way to determine if a person has impairment. *Id.*[6] Dr. Forehand acknowledged that if a patient he was examining was taking nitroglycerin for chest pains, as Claimant was during his exam with Dr. Rosenberg, it might raise concerns about conducting an exercise blood gas study. CX 2 at p. 32.

Dr. Forehand stated that the mechanism of arterial hypoxemia in coal miners comes from scarring around the blood vessels, as opposed to loss of the alveolar capillary bed described by Dr. Rosenberg, and that one will not see hypoxemia at rest and will instead have to exercise the miner. CX 2 at p. 20. Dr. Forehand stated that the sentence "air trapping is not present," counters the idea of a strictly ventilatory pattern. *Id.* Dr. Forehand testified that he does not consider Dr. Rosenberg's opinion to be medically reasonable because Dr. Rosenberg had information available from other reports that suggest that from a functional perspective, the miner could not perform his previous coal mining job. CX 2 at p. 25.

Dr. Forehand testified that he does not think that the exercise values achieved by Dr. Ranavaya on August 15, 2002 are exercise values, but are instead recovery values. CX 2 at p. 37. He explained that the only way one would get a PO2 of 107 is if the patient is vigorously exercised and then sits down. *Id.* Dr. Forehand further stated that he doubts Dr. Rosenberg's exercise PO2 value of 87 was drawn during exercise either. *Id.* Dr. Forehand testified that assuming hypothetically that there has been a fluctuation in the values of pulmonary function studies or arterial blood gas studies, it would indicate that it is a result of something other than pneumoconiosis and not a permanent disability if it occurred in an individual other than Claimant. CX 2 at p. 39.

Dr. Forehand described a pattern he termed a "recovery effect" where miners are exercised and "their PO2s were down in the 40s and 50s and you sit them down and rest them for

[6] Throughout the deposition, Employer objected to any testimony by Dr. Forehand concerning his own medical opinion, as the deposition was to be restricted solely to the rebuttal of Dr. Rosenberg's report, which is consistent with my ruling at the hearing. *See supra*, note 4. Claimant argues that because Dr. Forehand's conclusion is different from Dr. Rosenberg's conclusion, this in and of itself is a clear rebuttal of Dr. Rosenberg's opinion and, therefore, Dr. Forehand should be allowed to restate his own opinion. CX 2 at p. 29. I disagree. I am well aware of Dr. Forehand's opinion because his reports are already in the record. The purpose of the rebuttal is for Dr. Forehand to address any discrepancies, faulty reasoning, or methods in Dr. Rosenberg's report that may assist me in better understanding the medical evidence. Accordingly, Employer's objection is sustained, and any testimony by Dr. Forehand that merely reiterates his own medical opinion is disregarded.

two minutes and then draw another one and it's up in values that you couldn't imagine." CX 2 at p. 40. He explained that he is not sure whether anyone has studied the phenomenon but it in no way reflects what occurred during exercise. *Id.*

Dr. D. L. Rasmussen

Dr. Rasmussen, who is board-certified in internal medicine and a B-reader, examined the miner on July 19, 2001, completed Form CM-988, and submitted a report. His report appears in the record at DX 18. Dr. Rasmussen noted that the miner complained of shortness of breath for 11-12 years and now becomes significantly dyspneic after climbing a single flight of stairs. He recorded that the miner denied chronic cough, sputum production, orthopnea, or paroxysmal dyspnea, and noted that he wheezes at night, in rainy weather, and when exposed to strong odors such as perfumes and hairsprays, and suffers from ankle swelling. Dr. Rasmussen also noted that the miner reported coughing small amounts of blood, episodes of pleurisy, and attacks of wheezing while working, and also coughing small amounts of blood six months prior on two occasions. He noted that the miner described upper anterior pressure and numbness associated with exertion that is relieved by rest. Dr. Rasmussen recorded a history of high blood pressure but noted that the miner denied other cardiovascular illness.

Dr. Rasmussen recorded a family history that is positive for heart disease and stroke in the miner's mother, tuberculosis in his brother, and emphysema and black lung in his father. Dr. Rasmussen noted that the miner began smoking regularly at age sixteen in 1964 and smoked about one pack per day until he quit in 1997. Dr. Rasmussen recorded an occupational history of coal mining for 25 years, and that the miner's last employment was that of continuous miner operator and section foreman, which involved occasionally pulling heavy electrical cable and water line, carrying rock dust bags weighing 50 pounds 70 to 80 feet, and generally performed considerable heavy manual labor.

The miner's physical examination was essentially normal, and Dr. Rasmussen detected no bruits, rales, rhonchi, wheezes, or clubbing of the fingers. Dr. Rasmussen performed objective tests that included an EKG that revealed regular sinus rhythm and non-specific ST-T wave changes, a chest x-ray, ventilatory function studies, and arterial blood gas studies. He noted that spirometry revealed minimal, irreversible obstructive ventilatory impairment, maximum breathing capacity was markedly reduced showing significant improvement after bronchodilator therapy, the single breath carbon monoxide diffusing capacity was minimally reduced, and there was minimal impairment in oxygen transfer at rest.

Dr. Rasmussen exercised the miner via an incremental treadmill exercise study and he noted that the miner's volume of ventilation was moderately increased and he retained a breathing reserve of only 33 L/min, there was no increase in VD/VT ratio but there was marked impairment in oxygen transfer and he was at least moderately hypoxic. Dr. Rasmussen stated that these studies indicate marked loss of lung function and this degree of impairment would render the miner totally disabled for resuming his last regular coal mine job or for performing any significant manual labor.

Dr. Rasmussen stated that the miner has a significant history of exposure to coal mine dust and rather pronounced x-ray changes consistent with pneumoconiosis. He opined that it is medically reasonable to conclude that he has coal workers' pneumoconiosis that arose from his coal mine employment. Dr. Rasmussen stated that the two risk factors for the miner's disabling lung disease are his cigarette smoking and his coal mine dust exposure and his coal mine dust exposure is the major contributing factor to his disabling lung disease. He also noted that the miner might have poorly controlled systemic hypertension although an artifact in measurement cannot be excluded.

Dr. James R. Castle

Dr. Castle examined the miner on September 16, 2002 and reviewed the miner's medical records. He is board-certified in internal medicine and pulmonary diseases and is a B reader. His report appears in the record at DX 53. Dr. Castle performed objective tests that included a chest x-ray, pulmonary function studies, arterial blood gas studies, and an EKG. An exercise arterial blood gas study was not performed because Dr. Castle believed it to be medically contraindicated due to angina the miner's cardiac condition.

Dr. Castle opined, with a reasonable degree of medical certainty, that the miner has radiographic evidence consistent with simple coal workers' pneumoconiosis. He explained that the miner's exposure history was sufficient enough to have caused him to develop coal workers' pneumoconiosis if he were a susceptible individual. Dr. Castle noted that another risk factor for pulmonary symptoms is the miner's tobacco abuse history, which is sufficient enough to have caused him to develop COPD—i.e. chronic bronchitis/emphysema or lung cancer and/or atherosclerotic cardiovascular disease. Dr. Castle stated that another risk factor for pulmonary symptoms is cardiac disease and that the miner complained of ongoing chest pain and had evidence of possible ischemia on EKG.

Dr. Castle explained that the miner did not demonstrate any consistent findings indicating the presence of an interstitial pulmonary process of clinical significance, and did not have rales, crackles, or crepitations. He stated that the miner had occasional rhonchi or wheezes but the majority of exams indicate no abnormalities whatsoever. Dr. Castle noted that the miner had evidence of a mild degree of airway obstruction without restriction, the values of which were above DOL guidelines. He explained that on some occasions, there was a significant reversibility consistent with an asthmatic component to the airway obstruction, which makes it more likely that the obstruction is related to tobacco smoking. Dr. Castle stated that the intermittent reversibility leads him to conclude that the nondisabling obstruction is due to smoking but the miner does not have a disabling abnormality of pulmonary function.

Dr. Castle explained that the arterial blood gas studies have generally been within normal limits, with the only abnormal study during Dr. Rasmussen's exam in July 2001, when the miner had some hypoxemia with exercise. He noted that on all other exercise studies, the miner has not demonstrated any abnormality of oxygenation with exercise. Dr. Castle stated that this leads him to conclude that the problem during Dr. Rasmussen's exam was a transient phenomenon and unrelated to coal workers' pneumoconiosis because when coal workers' pneumoconiosis causes hypoxemia, it is not reversible due to the fixed nature of the disease process.

Dr. Castle opined, with a reasonable degree of medical certainty, that the miner has radiographic evidence consistent with simple coal workers' pneumoconiosis and he does have a mild respiratory impairment of an obstructive nature that is intermittently significantly reversible and non-disabling. He further opined that the miner retains the respiratory capacity to perform his usual coal mining employment duties. Dr. Castle opined that the impairment is most likely related to the miner's former tobacco smoking habit and while it is possible that there may be some minimal contribution to the obstruction due to coal workers' pneumoconiosis, he finds it to be unlikely due to the significant reversibility occurring periodically. Dr. Castle stated that regardless of the cause of the miner's obstruction, he does not meet the criteria established by the U.S. Department of Labor for total disability.

Dr. David M. Rosenberg

Dr. Rosenberg, who is board certified in internal medicine, pulmonary disease, and occupational medicine, and is a B-reader, reviewed the miner's medical records and also examined the miner on January 18, 2002. His report is dated January 31, 2002 and appears in the record at DX 30. He noted that the miner complained of being short of breath for ten years, with it worsening for the past five years. He noted that the miner could probably climb two flights of steps and walk level ground, but would be symptomatic walking fast or negotiating an incline. Dr. Rosenberg recorded that the miner reported hoarseness, but denied cough or sputum production except during a cold. He noted that the miner reported nighttime wheezing, slept on one pillow, takes a water pill for edema, and had a bad coughing spell with hemoptysis about one year prior. He noted that the miner reported chest discomfort but a past cardiac evaluation was negative.

Dr. Rosenberg recorded a family history that is positive for stroke in his mother and a brother, and lung disease in his father, and black lung in both his father and brother. Dr. Rosenberg noted that the miner denied a history of whooping cough, TB, asthma, or pneumonia but suffered from a sinus problem. He recorded a cigarette smoking history of a pack per day as a youngster and ending in 1996 and noted that the miner leads a sedentary life. Dr. Rosenberg recorded an underground coal mine employment history of 25 years, ending in 1994 due to back and lung problems. He noted that the miner engaged in roof bolting and at one point operated two miners that generated extra dust. He noted that the miner reported wearing a respirator about 75% of the time and that the job required lifting cable that weighed between 50 to 100 pounds. The miner denied any other employment over the years.

Physical exam revealed no accessory muscle use with equal expansion of the chest without rales, rhonchi, or wheezes, and auscultation revealed no murmurs, gallops, or rubs. Dr. Rosenberg noted that the miner's abdomen was protuberant without masses, and there was no edema, cyanosis, or clubbing. Dr. Rosenberg performed objective tests that included an EKG which was normal, chest x-ray, ventilatory studies, and resting and exercising arterial blood gas studies.

Dr. Rosenberg stated that based on a review of the information, the miner's chest x-ray reveals definite micronodular changes consistent with simple CWP. He explained that the

diffusing capacity measurement corrected for lung volumes was normal and indicates that the alveolar capillary bed within his lungs is intact. Dr. Rosenberg noted on exercising, the miner had normal gas exchange that corresponds to the normal diffusing capacity measurement. Dr. Rosenberg explained that the lung volume measurements were done with gas dilution methodology, and lung volume measurement using this technique can be artificially reduced because obstruction prevents the gas from being distributed throughout the lungs, which may well account for the reduced TLC.

Dr. Rosenberg opined that from a functional perspective, the miner has moderate airflow obstruction and had a significant bronchodilator response. He explained that while the miner had a mild restriction, this was associated with the preservation of his oxygenation gas exchange and his predominant physiologic abnormality is airflow obstruction and any restriction present is not contributing to significant exercise limitations, particularly in view of his normal gas exchange. Dr. Rosenberg explained that while COPD can be caused by coal dust exposure, since the miner's FEV1% is moderately reduced without the presence of conglomeration present and he had a significant bronchodilator response, he suspects the miner's obstructive impairment relates to his past smoking history. He explained that obstruction associated with CWP should be fixed in nature, without improvement after bronchodilators. Dr. Rosenberg emphasized that the miner's functional values exceed the lower limits for disability impairment in the federal regulations and this would allow him to perform his previous coal mining or similar arduous type of labor.

Dr. Rosenberg opined, with a reasonable degree of medical certainty, that the miner has simple, (category 2) coal workers' pneumoconiosis with some evidence of coalescence and his pulmonary function tests reveal mild restriction with moderate obstruction. He explained that the restriction possibly is related to his CWP but is associated with preserved gas exchange and while the miner has moderate obstruction with an asthmatic component, it probably relates to his extensive smoking history. Dr. Rosenberg opined that from a pulmonary functional perspective, the miner could perform his previous coal mining job or other similar work.

Dr. Rosenberg reviewed the miner's medical records and examined the miner again on November 4, 2004. (EX 1) His report is dated November 12, 2004, and appears in the record at EX 1. Dr. Rosenberg noted that the miner complained of chest discomfort on exertion that had a pressure quality to it and was relieved with nitroglycerin. He indicated that the miner was going to see his cardiologist about it, and that the miner was told that the only way to know for sure whether he has heart disease is to undergo cardiac catheterization. Dr. Rosenberg described the miner as being short of breath walking twenty feet or climbing a flight of steps. He noted that the miner complained of cough, sputum production, wheezing, and one pillow orthopnea. Dr. Rosenberg noted that the miner described awakening at night with shortness of breath and has some swelling of the legs, without hemoptysis.

Dr. Rosenberg indicated that the miner's family history was positive for stroke in his mother, black lung disease in his father, and death in three siblings due to stroke, black lung disease, and a probable heart attack. He noted that the miner began smoking cigarettes at age eighteen to twenty and smoked approximately a pack of cigarettes per day until about 1997. Dr. Rosenberg noted that the miner is fairly sedentary but mows the grass and gardens. Dr.

Rosenberg recorded 25 years of coal mine employment, with all of the work underground, and ending in 1994 when the mine closed. He noted that the miner worked as a section foreman and miner operator in an extremely dusty environment, mostly utilizing respiratory protection. Dr. Rosenberg recorded that the miner lifted cable weighing 30 to 40 pounds and did other work that required him to lift up to 75 pounds and moving it 80 feet.

On physical examination, Dr. Rosenberg noted the miner's lungs were clear and pulmonary function studies revealed moderate obstruction with a reversible component. He recorded that the miner did not have a restriction or a low DLCO/VA with his oxygenation being normal, and his chest x-ray revealed stable category 2 changes of simple CWP. Dr. Rosenberg stated that based on a review of information, the miner's chest x-ray continues to reveal category 2 changes of simple CWP, he continues to demonstrate areas of coalescence which are unchanged compare to his prior evaluation. He stated that the miner's TLC is 80% of predicted, which is stable and not decreased from his previous evaluation and is, perhaps, somewhat better. Dr. Rosenberg noted that the miner's diffusing capacity corrected for lung volumes is normal which indicates that the alveolar capillary bed within his lungs is intact and on auscultation, his lungs were clear. He stated that considering all of the above, the miner has stable simple CWP.

Dr. Rosenberg stated that from a functional standpoint, the miner continues to demonstrate a degree of airflow obstruction with a reversible component but overall, the obstruction has not appreciatively worsened over the last several years, being above disability standards. He opined that strictly from a pulmonary standpoint, he is not disabled from performing his previous coal mining job or similarly arduous types of labor. Dr. Rosenberg reiterated that a stress test could not be performed because of the miner's angina type pains. He explained that with the improvement of airflow after bronchodilators, the miner's airflow obstruction probably relates to his cigarette smoking history and a component of his airflow obstruction could relate to past coal dust exposure. Dr. Rosenberg stated that the miner's hypertension and suspected coronary artery disease does not relate to his coal dust exposure and has not been hastened by past coal dust exposure.

Dr. Rosenberg opined, with a reasonable degree of medical certainty, that the miner has stable simple CWP. He opined that he does not have restriction but has a degree of airflow obstruction that is above disability standards and from a functional perspective, the miner could perform his previous coal mining job or similarly arduous types of labor.

Dr. Rosenberg reviewed Dr. Forehand's October 7, 2004 evaluation and the transcript from his January 10, 2005 deposition, and submitted a rehabilitative report dated March 15, 2005. This report appears in the record at EX 2. Dr. Rosenberg explained that contrary to what Dr. Forehand stated in his deposition, the blood gases he obtained in his examination of the miner were not recovery blood gases because he was present at the time and the blood gas was obtained while the miner was exercising on a bicycle. He reiterated that the miner's PO2 did not fall with exercise.

Dr. Rosenberg stated that Dr. Forehand performed an exercise study in June 1994 where the miner's heart rate increased from 69 to 129 beats per minute and the miner's PO2 increased from 74 to 76 mmHg. He further emphasized that Dr. Ranavaya performed an exercise blood

gas study in August 2002, and the miner's heart rate increased from 68 to 123 beats per minute and his PO2 values increased from 81 to 107 mmHg. Dr. Rosenberg explained that these findings show that the drop in PO2 observed by Dr. Forehand in August 2003 clearly does not represent a consistent finding with respect to the miner, the variability of oxygenation would indicate the miner does not have a permanent type of oxygen impairment related to past coal dust exposure, and if the miner's simple CWP were causing physiologic impairment, the fall in PO2 would be a permanent condition. Dr. Rosenberg noted that the miner had a significant improvement in spirometry values after administration of bronchodilators and this is also not consistent with fixed impairment related to CWP.

Dr. Rosenberg emphasized that the post-bronchodilator results that he obtained in November 2004 were clearly well above DOL disability standards and the post-bronchodilator spirometric values obtained by Dr. Forehand in October 2004 are well above DOL disability standards. He stated that the PO2 values measured by both himself and Dr. Forehand are not disabling.

Dr. Rosenberg stated, with a reasonable degree of medical certainty, that while the miner has simple CWP, he is not disabled from a pulmonary perspective based on the fact that his spirometric values clearly are above disability standards, as were the blood gas values at the time of his examination. He reiterated that he did not perform exercise blood gas testing because of the miner's angina, but his previous obtained values did not reveal a fall in PO2, representing normal gas exchange. In addition, Dr. Rosenberg explained that both Dr. Forehand, in 1994, and Dr. Ranavaya, in 2002, obtained normal gas exchange values. Dr. Rosenberg stated that the variability of blood gas results, along with the improvement of spirometric values after bronchodilators, is not consistent with fixed impairment related to past coal dust exposure.

Conclusions of Law

Length of Coal Mine Employment

The parties have stipulated and I find that Claimant was a miner within the meaning of the Act for 22.9 years. Tr. 5.

Date of Filing

I find that Claimant filed his claim for benefits under the Act on March 19, 2001. (DX 3; Tr. 7)

Responsible Operator

Employer does not contest that it is the responsible operator. Accordingly, I find that Koch Carbon Raven Division is the responsible operator and will provide payment of any benefits awarded to Claimant. (DX 77)

Dependents

I find that Claimant has two dependents, his wife, Joyce, and his son, Ethan, for purposes of augmentation of benefits under the Act. (DX 13; Tr. 19) [7]

Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra*; *Fagg v. Amax Coal Co.*, 12 B.L.R. 1-77 (1988); *aff'd*, 865 F.2d 916 (7th Cir. 1989); *Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983); *see also Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge to determine. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985); *Peabody Coal Co. v. Benefits Review Board*, 560 F.2d 797, 1 B.L.R. 2-133 (7th Cir. 1977).

As the trier-of-fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The Existence of Pneumoconiosis

In her July 30, 2003 Decision and Order, Judge Chapman found that Claimant established the existence of pneumoconiosis, and therefore established a material change in condition from his previous claim. In addition, Employer stated that while it is not willing to stipulate to the existence of pneumoconiosis, it is also not seriously contesting the issue. Tr. 6. As previously discussed, in evaluating a request for modification, I am required to conduct a *de novo* review of the record and to determine whether there was a mistake in a determination of fact. Accordingly, I have evaluated the pneumoconiosis evidence.

[7] The Final Order of Adoption of Ethan appears in the record at DX 17.

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by reasoned medical opinion. 20 C.F.R. § 718.202(a).

Additionally, the Fourth Circuit Court of Appeals held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffers from coal workers' pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1 does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986).

Where two or more x-ray reports are in conflict, the radiographic qualifications of the physicians interpreting the x-rays must be considered. 20 C.F.R. § 718.201(a)(1). The interpretations of physicians who are dually-qualified (board-certified radiologists and B-readers) are entitled to the greatest weight. The Benefits Review Board held that it is proper to credit the interpretation of a dually-qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999)(en banc on recon.).

Of the submitted evidence, there were six interpretations of five chest x-rays, five of which were positive and one of which was negative. Of these six interpretations, there was one positive interpretation by a physician whose qualifications are unknown and two positive interpretations by B-readers. There were two positive interpretations by dually-qualified physicians, while the one negative interpretation was also by a dually-qualified physician. Additionally, the two most recent x-ray interpretations were positive. Accordingly, as the majority of dually-qualified and B-reader interpretations are positive for pneumoconiosis, including the most recent x-ray evidence in the record, I find that Claimant has established, by the preponderance of the chest x-ray evidence, the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1).

Biopsy Evidence

Pursuant to 20 C.F.R. § 718.202(a)(2), Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, pneumoconiosis is not established in this manner.

Complicated Pneumoconiosis

There is no evidence that the miner suffers from large opacity, complicated pneumoconiosis; therefore, he is not entitled to the irrebuttable presumption set forth at 20 C.F.R. § 718.304.

Medical Opinion Evidence

Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination, constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an administrative law judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The reports of four physicians were submitted in the current claim regarding Claimant's medical condition. Drs. Forehand, Rasmussen, Castle, and Rosenberg all opined that Claimant suffers from coal workers' pneumoconiosis. All of the physicians reviewed the miner's medical records and all of the physicians examined the miner and performed objective tests. Therefore, I find that all of their opinions are well-documented. Further, all of the physicians based their opinions on their physical examinations of the miner, work and social histories and objective tests. Therefore, I also find that they are well-reasoned. Accordingly, I find that the miner has established the presence of coal workers' pneumoconiosis pursuant to the current medical opinion evidence at 20 C.F.R. § 718.202(a)(4).

Pursuant to the holding in *Compton*, *supra*, I must weigh all of the evidence under 20 C.F.R. § 718.202(a) together in order to make a determination regarding the existence of pneumoconiosis. I previously found that Claimant established the existence of pneumoconiosis through the chest x-ray evidence and the medical opinion evidence at §§ 718.202(a)(1) and 718.202(a)(4). I also found that there is no biopsy evidence in the record and that the presumptions at § 718.202(a)(3) are inapplicable to this case. Accordingly, weighing all of the evidence together, I find that Claimant has established the existence of pneumoconiosis pursuant to § 718.202(a) and *Compton*. Moreover, I find that Judge Chapman did not make a mistake in fact in finding that Claimant established that he suffers from pneumoconiosis.

Cause of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. Twenty C.F.R. § 718.203(a)(2003) provides that if a miner who is suffering from pneumoconiosis was employed for ten or more years in the coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of that coal mine employment.

I find that Claimant, with at least 22.9 years of coal mine employment, is entitled to the rebuttable presumption at § 718.203. Moreover, all of the physicians attributed the miner's coal workers' pneumoconiosis, at least in part, to his coal mine employment. For these reasons, I find that Employer has not submitted sufficient evidence to rebut this presumption.

Because Claimant established that he suffers from pneumoconiosis arising from his coal mine employment, an element of entitlement previously adjudicated against him, he has established a change in condition pursuant to 20 C.F.R. §§ 725.309(d) and 725.310 (2003). I will now evaluate the entire record to determine whether all the rest of the evidence establishes that Claimant is entitled to benefits.

Evidence of Total Disability and Disability Causation

Judge Chapman denied Claimant's claim because he failed to prove that he was totally disabled due to pneumoconiosis on the merits. Total disability is defined as pneumoconiosis that prevents or prevented a miner from performing his usual coal mine employment or other comparable gainful work. 20 C.F.R. §§ 718.305(c), 718.204(b)(1) (2003). A finding of total disability may be based on the criteria found in § 718.204(b)(1), which provides that a miner will be considered totally disabled if the irrebuttable presumption set forth in § 718.304 applies,[8] or may be established by the criteria set forth in § 718.204(b)(2), which consists of qualifying pulmonary function studies, qualifying blood gas studies, the existence of cor pulmonale with right sided congestive heart failure, and the opinion of a physician, exercising sound medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluding that the miner's pulmonary condition prevents him from performing his usual coal mine work.

I previously found that Claimant is not entitled to the irrebuttable presumption set forth in § 718.304. In addition, there is no evidence that he suffers from cor pulmonale with right-sided congestive heart failure.

There are seven pulmonary function studies in the record submitted in connection with the current claim, none of which are qualifying. In addition, there are six pulmonary function studies that were submitted with the previous claim and none of those are qualifying. Accordingly, I find that Claimant failed to establish total disability pursuant to the pulmonary function study evidence at § 718.204(b)(2)(i)(2003).

[8] There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if a chest x-ray yields one or more large opacities (greater than 1 centimeter) and would be classified as Category A, B, or C as further specified in the Regulation.

There are eleven arterial blood gas studies in the record, five from the miner's previous claim and six from the current claim. The only study that is qualifying is the exercise arterial blood gas study taken on July 19, 2001. None of the previous or subsequent resting or exercising studies is qualifying, including the most recent studies. Accordingly, I find that Claimant has not established total disability pursuant to § 718.204(b)(ii)(2).

The reports of five physicians, Drs. Mitchell, Sargent, Forehand, Ranavaya, and Fino were submitted in connection with the miner's previous claim. Drs. Sargent, Ranavaya, and Fino opined that the miner is not totally disabled. Dr. Mitchell did not address the issue at all, and Dr. Forehand opined that the miner has a mild to moderate impairment. Of these opinions, I find that only Drs. Sargent and Fino's opinions are well reasoned. Dr. Mitchell never addressed the miner's respiratory capabilities, and Drs. Ranavaya and Forehand never discuss the miner's respiratory capacity in relation to his previous coal mine employment. Dr. Forehand merely recommends that the miner find an alternative environment to avoid aggravating his symptoms. Accordingly, I find that Claimant has not established that he is totally disabled by the previous medical opinion evidence.

Four physicians who have rendered an opinion in connection with the miner's current claim. Of the four, Drs. Forehand and Rasmussen opined that the miner is totally disabled from performing his previous or similar coal mine work. By contrast, Drs. Castle and Rosenberg opined that the miner retains the respiratory capacity to perform his usual coal mine work or similar work. All of the physicians based their opinions on the miner's medical records and objective tests. In addition, all of the physicians examined the miner.

Dr. Forehand, who is the miner's treating physician, opined that the miner suffers from exercise induced arterial hypoxemia. He based his opinion on the miner's physical symptoms, coal mine employment history, and pulmonary function studies and arterial blood gas studies, in particular the results of the miner's exercise arterial blood gas studies.

Dr. Rasmussen examined the miner and performed objective studies. He stated that spirometry revealed minimal, irreversible obstructive ventilatory impairment, maximum breathing capacity was markedly reduced but improved after bronchodilators, and there was minimal impairment in oxygen transfer at rest. Dr. Rasmussen found that after exercise, there was marked impairment in oxygen transfer and the miner was moderately hypoxic. He opined that the breathing studies indicate marked loss of lung function to a degree of impairment that would render the miner totally disabled from resuming his last coal mine job or similar manual labor.

Dr. Castle examined the miner, performed objective studies, and reviewed the miner's medical records. Dr. Castle noted that the majority of the miner's physical exams indicated no abnormalities, that the miner has evidence of a mild degree of airway obstruction without restriction, there was significant reversibility on some occasions, and he opined that the miner does not have a disabling abnormality of pulmonary function. Dr. Castle observed that the arterial blood gas studies have been within normal limits and only Dr. Rasmussen's exercise study was abnormal. He opined that the miner's problem during Dr. Rasmussen's exercise exam

was transient and unrelated to coal workers' pneumoconiosis, because hypoxemia due to coal workers' pneumoconiosis is not reversible due to the fixed nature of the disease process. Dr. Castle opined that the miner does have a mild respiratory impairment that is of an obstructive nature, which is intermittently significantly reversible and non-disabling. Dr. Castle further opined that the miner retains the respiratory capacity to perform his usual coal mining employment work.

Dr. Rosenberg examined the miner on two occasions, performed objective tests, and reviewed the miner's medical records. Dr. Rosenberg opined that the miner has a degree of airflow obstruction that is above disability standards and from a functional standpoint, the miner could perform his previous coal mining job or similarly arduous types of labor. Dr. Rosenberg stated that he based this opinion on the fact that the miner's spirometry values and arterial blood gas values are above disability standards and that the variability of the blood gas results, along with the improvement of spirometric values after bronchodilators, is not consistent with fixed impairment related to past dust exposure.

In weighing the physician's opinions, I note that all of them are based on both objective tests and the miner's physical complaints. All of the physicians were aware of the exertional requirements of the miner's previous coal mine work. In addition, all of them indicate the presence of at least a minimal abnormality. However, I find the opinions of Drs. Rosenberg and Castle are better reasoned and more supportive of the objective evidence in the record than those of Drs. Forehand and Castle.

Although Dr. Forehand is the miner's treating physician, he did not sufficiently address the variability in the miner's exercise arterial blood gas studies, other than to speculate during his deposition testimony that Dr. Rosenberg's exercise study was not actually drawn during exercise, which Dr. Rosenberg disputed. Dr. Forehand also acknowledged in his deposition testimony that a fluctuation in the spirometry or arterial blood gas studies would indicate something other than pneumoconiosis or a permanent disability, if it occurred in a person other than Claimant. Accordingly, I find that Dr. Forehand's opinion is entitled to less weight despite the fact that he is the miner's treating physician.

Dr. Rasmussen, unlike Drs. Rosenberg and Castle, did not have the benefit of reviewing the miner's subsequent arterial blood gas studies, in particular the exercise studies of Drs. Ranavaya and Rosenberg, which produced non-qualifying values. In addition, he also did not review the non-qualifying results from earlier arterial blood gas studies. Because Dr. Rasmussen based his opinion that the miner is totally disabled on the results of his own exercise arterial blood gas study, and did not consider the later improving studies or the earlier studies, I find that his opinion is entitled to less weight than those of Drs. Rosenberg and Castle.

The opinions of Drs. Rosenberg and Castle are better supported by the totality of the medical evidence in the record, including the miner's physical examinations, because they both fully address the variation in the spirometry and the arterial blood gas study results. Accordingly, I find that they are entitled to greater weight than the opinions of Drs. Rasmussen and Forehand. In weighing the physician opinion reports together, from both his current and previous claims, I find that Claimant has not established, by a preponderance of the medical

opinion evidence, that he is totally disabled from performing his previous coal mine work or comparable work pursuant to 20 C.F.R. § 718.204(b)(2)(iv)(2003).

Weighing the pulmonary function study evidence, the arterial blood gas study evidence, and the physician opinion evidence together, I find that Claimant has not established that he is totally disabled from performing his usual coal mine work. In addition, I also find that Judge Chapman did not make a mistake in fact in determining that the miner did not establish that he is totally disabled due to pneumoconiosis. Moreover, because Claimant has not established that he is totally disabled, he cannot establish disability causation.

Conclusion

As Claimant failed to establish all of the requisite elements of entitlement, I find that he is not entitled to benefits under the Act.

Attorney's Fees

The award of attorney's fees under the Act is permitted only in cases in which benefits are awarded. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for the representation of services rendered to him in pursuit of this claim.

ORDER

The claim of Alfred William Hill for black lung benefits under the Act is hereby denied.

A

STEPHEN L. PURCELL
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the Office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.